PEDIATRIC
OCCUPATIONAL
THERAPIST
SAN FRANCISCO, CA

Referral Questionnaire

Child's Name: DOB:

Parent's name(s): Occupation:

Occupation:

Address:

School Name: Grade:

Teacher:

Referred By:

What do you hope to gain from your child's occupational therapy assessment and/or treatment?

Does or has your child received any other evaluations or therapies (OT, SLP, PT, psychologist, etc.)? If so, please include service and with whom.

What are your child's strengths/interests?

Describe how your child likes to spend time.

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Please describe your child's developmental challenges and when you first noticed them.

What are your primary concerns for your child?

Developmental/Health History

1. To the best of your ability, please indicate the approximate age your child met each developmental milestone:

Sat without support	Crawled**
Walked without assistance	How long did he/she crawl?
Spoke first word	Spoke in two word phrases
Stopped using bottle	Fed self with fingers
Potty trained	Fed self with spoon
Started dressing self	Dresses self w/o help
Buttoned shirt	Tied own shoes

2. Was your child born after a full term pregnancy? If no, length of time.

3. Were there any complications during pregnancy/birth? If yes, please explain.

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4. Has your child had a major illness or hospitalization?

5. Did your child enjoy being held from infancy to two years of age?

6. Was your child difficult to calm as a baby?

7. Has your child ever had seizures? If yes, when?

8. Does your child have problems in any of the following areas? (please check).

☐ Vision ☐ Speech ☐ Hearing ☐ Balance

Other? Please explain

9. Does your child have a history of ear infections? When/how often?

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10. Does your child take any medications? (please list).

11. Does your child have any allergies or food restrictions?

12. Has your child received a medical diagnosis? (if yes, please note when & by whom).

Family History

1. Siblings (name/ages)

2. Is there any history in your immediate or extended family of learning problems, motor problems, mental illness, or similar difficulties that your child is experiencing?

3. Please note family hand dominance. R=right; L=left; M=mixed

Child Mother Father

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4. Has your child experienced the death of a family member, close friend, or pet? (if so, please note when).

5. Has your child witnessed or been the victim of crime or abuse?

6. Are there current stresses in the family or child's life?

7. If your child was adopted, do you have information about the birth mother's health and pregnancy or any information about parent family history?

Communication/Play Skills

1. If your child is nonverbal, please describe how your child communicates and the types of vocalizations your child uses.

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2. If your child is verbal, please describe your child's verbal abilities (vocabulary, ability to stay on topic, etc.)

3. Describe your child's typical play skills. Please include information about ages of the people your child plays with; if your child chooses to be a leader, follower, or a loner; how many people your child is comfortable playing with at once; and whether your child prefers a few close friends or a lot of acquaintances, etc.

Self Care/Daily Routines

1. Describe your child's typical mealtime routine. Please include typical foods, any food sensitivities, where your child eats, use of utensils, typical appetite, and behaviour during meal or snack times.

2. Describe how your child gets dressed. Please include the types of clothing your child wears, how independent your child is, how long it takes to get dressed, and typical behavior during dressing and undressing.

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3. Describe your child's typical bath time routine. Please include level of independence, your child's like or dislike of bath time, and your child's behavior before, during, or just after bath time.

4. Describe your child's level of independence and behavior during the following activities:

Teeth brushing:

Hair brushing:

Washing hands & face:

5. Describe your child's toileting skills. Please include level of independence, frequency of daytime accidents, bed wetting, awareness of toileting needs, etc.

6. Describe your child's typical bedtime routine, including significant behaviors and any strategies you use during this time.

7. Describe your child's typical wake up routine, including significant behaviors and any strategies you use during this time.

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8. Describe your child's typical night sleep, including number of hours, where your child sleeps, bed wetting, number of times your child wakes up, nightmares, etc.

Behavior, Attention, Self-Regulation

1. Describe how your child transitions between people, environments, and activities. Please include level of independence during transitions, need for transition object, advance preparation, etc.

2. Does your child seem irritable at predictable times of the day? If yes, please describe the times of day and the events that seem to trigger irritability.

3. Does your child seem happier, more engaged, or more cooperative at predictable times of the day? If yes, please describe the times of fay and the events that trigger these behaviors.

4. Does your child use any strategies to help sustain focused attention? If yes, please describe.

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5. Describe how your child approached and explores a new environment. Include information about how they interact in a quiet environment compared to an environment with many people or stimuli.

6. Describe how your child approaches a new activity or toy. Include information about how your child initiates new activities; your child's understanding of how to play with new toys; does your child use a toy in a variety of ways or is the play always the same, etc.

Sensory Components

1. Describe your child's reaction to touch. Include information about your child's behavior regarding being touched, touching other people or things, clothing likes or dislikes, how your child uses touch to explore, sensitivities, etc.

2. Describe how your child reacts to movement. Include information about types of movement your child likes or dislikes, the frequency that your child seeks movement, any avoidance of playground equipment, your child's behavior regarding being moved or being off the ground, sensitivities, etc.

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3. Describe your child's body awareness and safety awareness. Include information about your child's ability to maneuver around peers, adults, and objects; does your child bump into people or knock things over; awareness of danger; etc.

4. Describe your child's reaction to sounds. Include the types of sounds your child enjoys or dislikes, your child's ability to filter out irrelevant sounds, your child's reaction to loud sounds, your child's ability to follow verbal directions, etc.

5. Describe your child's visual attention. Include information about sensitivity to light, ability to attend to relevant visual information, ability to sustain visual attention, what typically catches your child's visual attention.

School Aged Children

1. Does your child have a listening or attention problem?

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2. Does your child have difficulty with handwriting or fine motor tasks?

3. Does your child reverse letters or numbers when reading or writing?

4. What are your child's academic strengths?

5. What are your child's academic challenges?

6. Describe your child's ability to complete homework. Include level of independence, need for breaks, external supports (snacks, 1:1 attention, music, etc.), the amount of time needed, etc.

7. Describe your child's ability to keep track of personal belongings and organize personal belongings (i.e. homework, bedroom, desk, etc).